Adult REACH Annual Report: Fiscal Year 2016

This report provides a review of the Adult REACH programs for fiscal year 2016. The year has largely been one of program consolidation and continued stabilization. The REACH standards have been in place for a full year and have provided beneficial structure and consistency to REACH, encouraging the five regional programs to function as a statewide system. A minor change to practices in Emergency Services crisis responding, requested by DBHDS and initiated in January of 2016, has greatly increased the number of psychiatric prescreening assessments that REACH staff are aware of and in which they are able to participate. While this has not reduced rates of hospitalization, it has enabled REACH to work with systems sooner and to provide needed assistance with discharge planning and step-down services. Region IV's new Crisis Therapeutic Home (CTH) is nearly complete, and there are plans to fully relocate the program in October 2016. Finally, DBHDS has moved forward with plans to ensure that all REACH teams have at least two members who have received training as Positive Behavior Support Facilitators (PBSF). This class began in August. It is hoped that all REACH staff who participate in this training will complete the required portfolios and mentoring to become endorsed by this time next year.

Some areas of challenge are also worthy of comment. The Data Store, which became operational approximately one year ago, has not yet been able to serve as a standalone data collection system. Only one region has been able to rely on the Data Store for quarterly reporting, and this only for the fourth quarter. Some manual collection and reporting is still required for certain data elements that are not captured by the current version of the Data Store. DBHDS is working with New River Valley Community Services Board IT staff to address concerns with the system. The Department recently held an all day meeting with REACH leadership and data entry personnel to facilitate a comprehensive review of implementation and entry into the Data Store, review and clarify all operational definitions, and reinforce data expectations from the Department's perspective. This was a very positive and productive meeting for all involved. This meeting occurred on August 16th and the goal is to have definition at the beginning of the second quarter of FY17. During fiscal year 16, the Department has been actively monitoring psychiatric hospitalizations and has recently completed a study, which has been summarized in a retrospective review with recommendations. Plans to ensure the availability of residential providers skilled in the treatment and management of severe behavior disorders are still underway.

With the background above providing an overarching context, this report will focus on identifying meaningful trends in the data that may inform decisions about the programs going forward. While some regional comparisons may be considered at times, this report will focus on areas related to the statewide system of care.

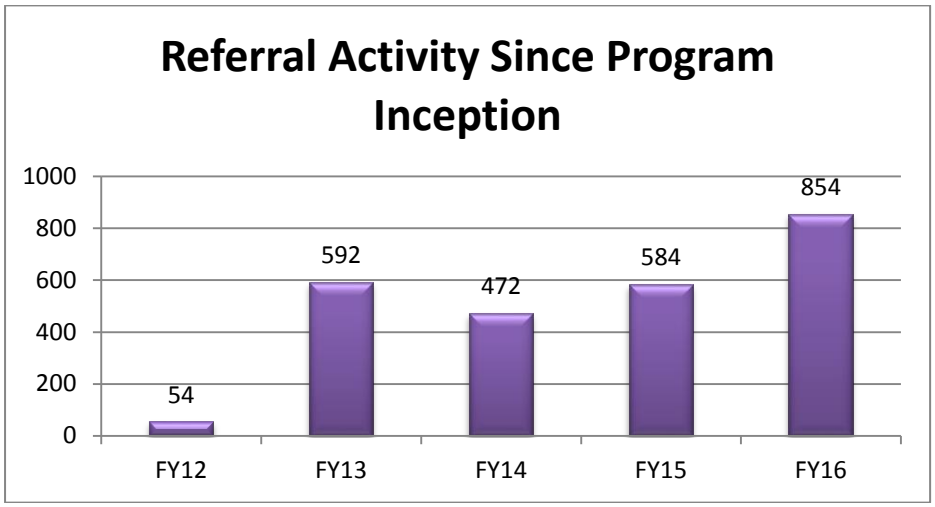
Referral Information

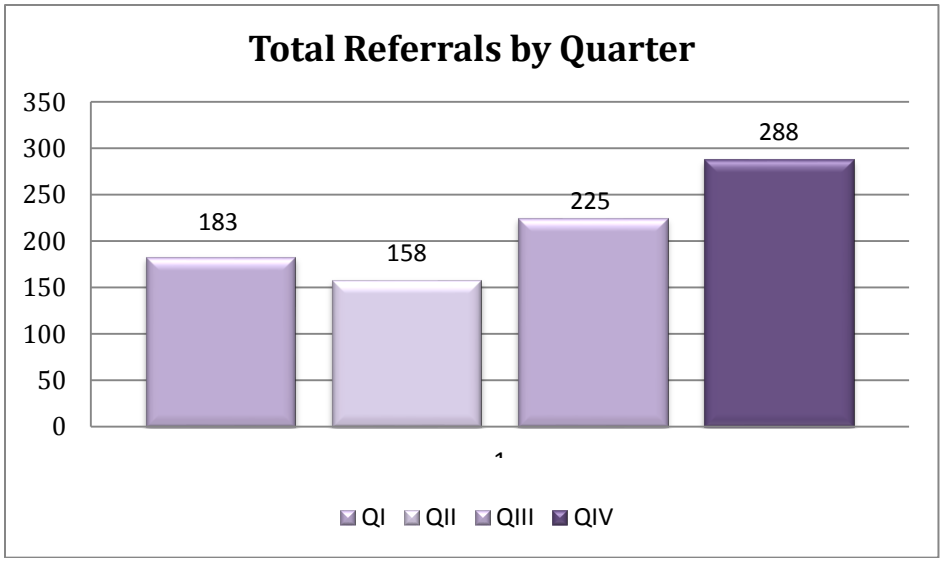
The REACH programs received at total of 854 referrals for service during Fiscal Year 2016. This is an increase of about 32% over Fiscal Year 2015 referrals. This is a large increase. Fortunately, the regions have been able to keep pace with this increased demand for services by hiring additional staff as needed. Within the year, REACH has seen a steady increase from quarter to quarter, with a small dip during the winter quarter. This is in keeping with previous years, when the holiday months depressed referral activity.

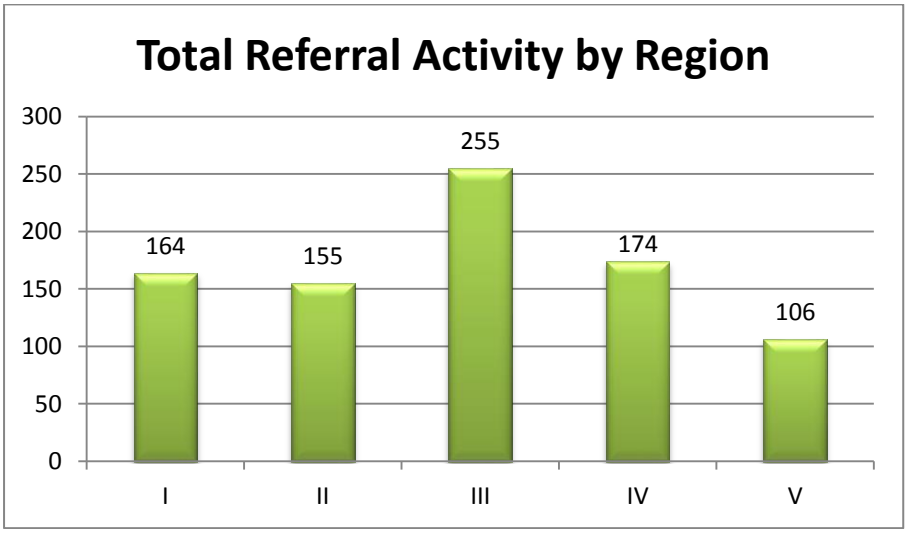
The distribution of referral activity has shifted away from being evenly allocated at about 20 percent per region as it was in FY15 to having two regions depart from this. Region III received the largest number of referrals at 30% and Region V the fewest at 13%. Interestingly, the remaining regions evenly divided the remaining requests for service. The significant increase for Region III appears to stem from the impact of the more stringent guidelines put in place to ensure that Emergency Services contact REACH as soon as they suspect an individual has a diagnosis of ID or DD. While this change should affect all regions equally, it is noteworthy that only Region III serves four state hospitals: Western State Hospital, Catawba, Southwestern Virginia Mental Health Institute, and Southern Virginia Mental Health Institute. This has resulted in their being involved in a large number of prescreening evaluations, which then lead into referrals to the program.

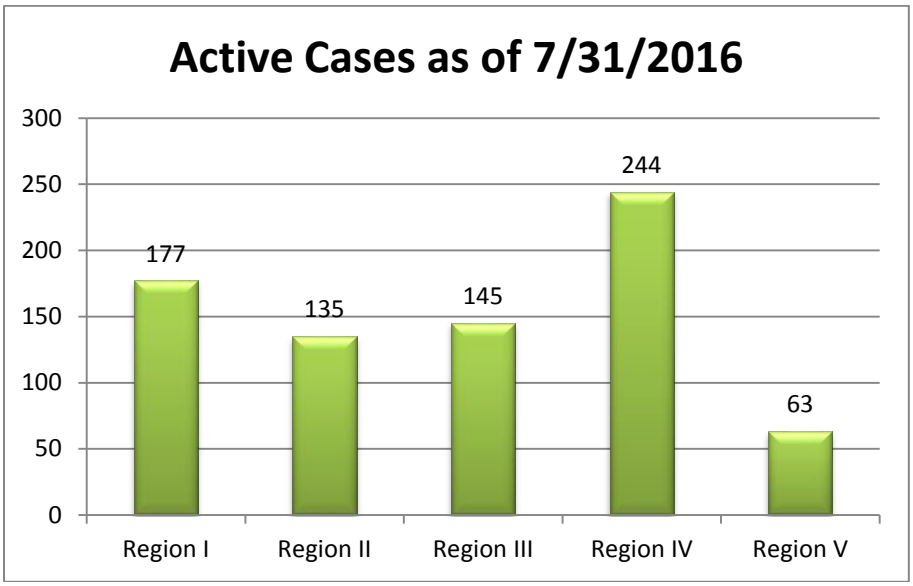
At the time of last year's report, Region V had established a clear trend of declining referrals. Their total referrals have been low throughout this fiscal year, although the Region saw an increase in referral activity toward the end of the fiscal year. Region V has had chronic difficulties with providing accurate data to the Department, and they are now working to establish appropriate data collection, maintenance, and reporting practices. These difficulties may account for some aspect of the low rates of referral. Data collection concerns aside, however, the Region appears to have lost some of the confidence of its stakeholders. This is evident in the fact that they do not receive referrals from families or emergency services staff. Their referrals come overwhelmingly from CSB case management. It is again apparent when one considers the number of active cases they had open as of the end of July 2016. At only 63 cases, they are serving a much smaller number of individuals than their counterparts. The Department is working with Region V very closely to determine the reasons for low referrals and to remediate any issues found including data collection/reporting and lack of referrals from families and emergency services.

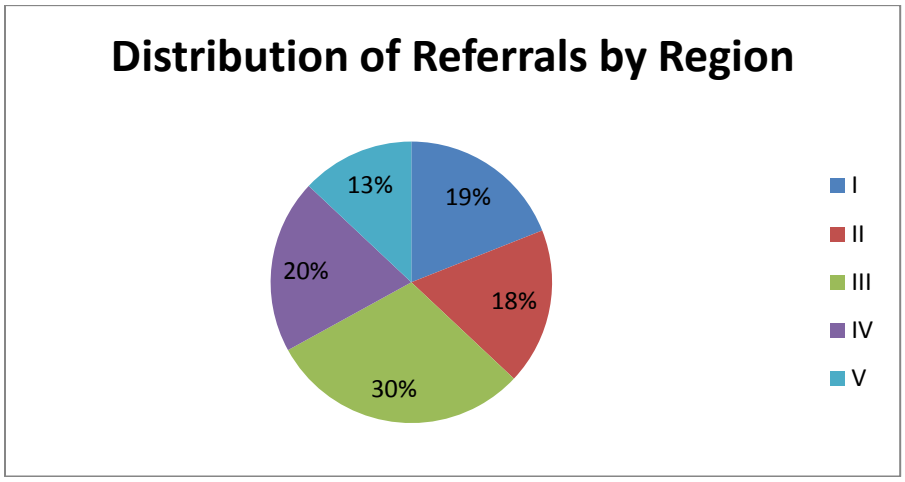
The graphs below summarize various aspects of referral activity as discussed in this report and present this information visually.

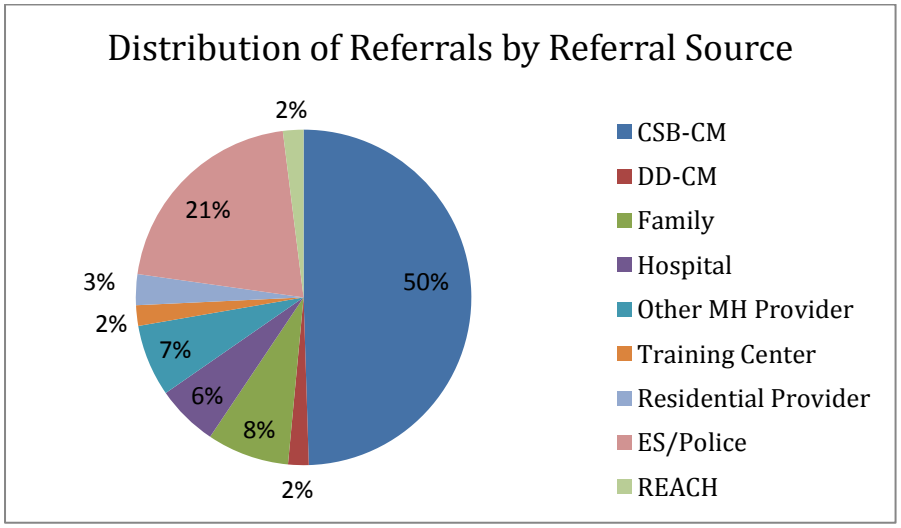

Referral Activity Since Program Inception
1000
800
600
400
200
0
54
592
472
584
854
FY12
FY13
FY14
FY15
FY16


Total Referrals by Quarter
350
300
250
200
150
100
50
0
183
158
225
288
QI
QII
QIII
QIV


Total Referral Activity by Region
300
250
200
150
100
50
0
164
155
255
174
106
I
II
III
IV
V


Active Cases as of 7/31/2016
300
250
200
150
100
50
0
177
135
145
244
63
Region I
Region II
Region III
Region IV
Region V


Distribution of Referrals by Region
19%
18%
30%
20%
13%
I
II
III
IV
V


Distribution of Referrals by Referral Source
50%
2%
8%
6%
7%
2%
3%
21%
2%
CSB-CM
DD-CM
Family
Hospital
Other MH Provider
Training Center
Residential Provider
ES/Police
REACH

Referral source data over the course of the past year was relatively consistent for the first three quarters. However, by the third quarter, data on the source of referrals showed an increase in activity from emergency services staff. Last fiscal year, these referrals accounted for only 5.2% of service requests. This year that number has risen to 25%. The policy change that went into effect in January of 2016 is the most likely reason for this change. The impact was not immediate, as protocol changes always take time to implement fully. A review of the data supports this conclusion as a notable increase was apparent by the fourth quarter of 2016. Region I saw the greatest impact, going from only 9% of referrals originating with emergency services in Quarter I to 42% by the end of the fiscal year. Neither Region II nor IV were receiving referrals from emergency services during the first quarter of the fiscal year, but by the years' end these numbers had jumped to 26 and 23 percent, respectively. Region III, which has routinely been receiving referrals from emergency services, also saw a substantial jump, with 27% of referrals coming from this source in Quarter I and 43% by the end of the fiscal year. Region V reported no referrals from emergency services during the entire course of the year. This may reflect the challenges that they have faced in being viewed as vital partners to emergency services staff as well as concerns that were determined through the quarterly review process regarding how they document referrals and open cases.

When viewed globally from aggregate totals for the year, CSB case managers were the most active source of service requests for REACH services. As touched upon in previous reports, this may be a function of the role that case managers assume in supporting the individuals on their caseloads. One major element of a case manager's job is to ensure that their clients are receiving the services they need to be happy and successful in the community. This involves coordinating service that may be identified by family members, therapists, residential providers, or other professionals who work with the person. Therefore, while the case manager may make the actual referral to a REACH program, the true request for care may come from a variety of sources. To ensure that data collected depict the most accurate information, the Department provided additional clarification regarding this data element during a directors meeting in May, clarifying that referral source is documented as the first person who makes the call and not once all the paperwork is completed. This will bring more variability to the data and enable programs to better target their outreach efforts toward those sources that may not be accessing REACH to the degree they could.

Who is Served by the REACH Program?

General demographic information can be useful as a way to formulate an understanding of the type of individuals seeking REACH services. Gender, age, and level of intellectual disability provide a basic framework for describing the population served during FY16. Given that there do not appear to be any systematic differences between the five regions, all data related to descriptive information will be presented in aggregate.

- Gender: For FY16, the REACH programs served 524 males and 330 females. Converting these figures into percentages indicates that 61% of individuals utilizing REACH programs are male and 39% are female. These numbers have changed very little since FY15 when 63% of referred individuals were male and 37% female. These numbers are consistent with the general literature on behavioral and mental health problems in the DD population, which find that males present with symptoms of mental health/behavioral problems at a higher rate than their female counterparts.

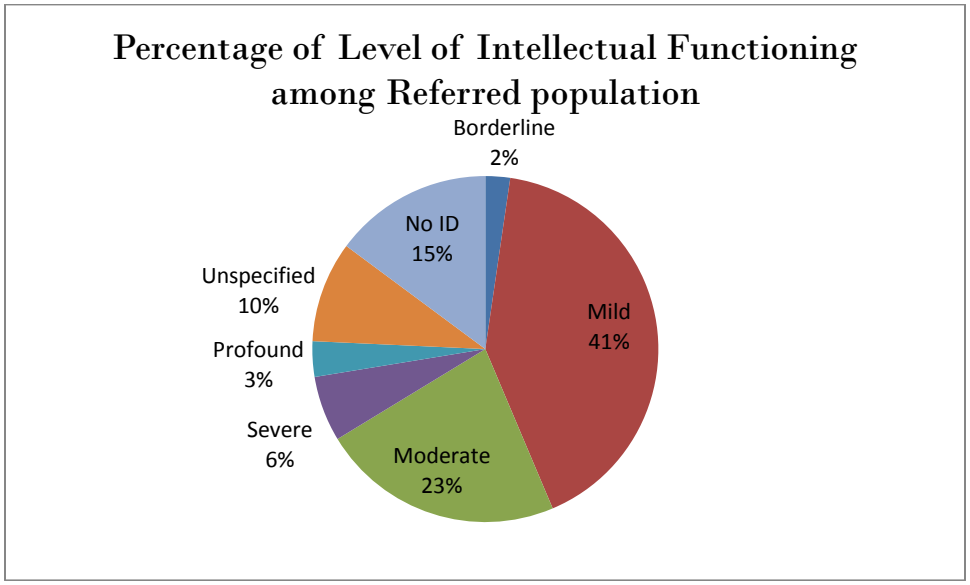
- Age: During FY16, the adult REACH programs served individuals from the ages of 18 to 71. The chart below provides a view of age distribution as defined by the age ranges noted. At the time of the last annual report, it was noted that a trend appeared to be emerging that indicated an increased need for crisis services for those within the 18-25 age range. The table below indicates that 42% of referrals come from individuals in these transitional years, followed by those in the mid-range, which accounts for an additional 34%. This 8% difference is noteworthy, but insufficient to indicate a robust trend or the need to make program changes to accommodate the young adult population. It will be very important to continue to monitor this data. Continued and higher rate growth in the need for services for those within the 18-25 age range may yet emerge and point to different service needs. Children's services have been fully operational in the state for much of fiscal year 2016. Many children served by the children's program are approaching adulthood and are being referred to the adult programs as a preventative measure. This may result in higher rates of referrals for young adults whose needs for skill building and acquisition will likely be unique and allow for prevention services to be particularly appropriate.

Age Range	Region I*	Region II	Region III	Region IV	Region V	Total
18-25	78	79	77	78	45	357
26-45	51	52	85	64	40	292
46-65	26	24	84	28	21	183
65+	8	0	9	4	1	22
	*No information for 1 person					

- Level of Intellectual Disability: The REACH programs support individuals across the entire spectrum of intellectual functioning. This is often a challenging aspect of their work, particularly within the crisis therapeutic homes, where the skill set needed to be effective with an individual functioning in the average (or above average) range of intelligence can be quite different from what is needed to serve people within the severe or profound range. Additionally, individuals at the lower end of the spectrum of intellectual disability are more likely to have sensory

challenges, unique medical concerns, and more limited mobility. The REACH programs must be prepared to meet these needs as well as they meet those of individuals with average intellectual functioning who may be preparing for an increased level of independence. Therefore, monitoring and using this information is important in program development, staff training, and discharge planning.

During FY16, the REACH programs did work with individuals of all levels of intellectual disability, as well a small number of persons within the range of normal intellectual functioning. As expected and in keeping with last year's data and known epidemiological research, most individuals served by the REACH program fall within the mild range of intellectual disability, followed by those with a moderate level of impairment. Given that this distribution follows that of established morbidity rates, it is not anticipated that this will substantially change. The chart below summarizes the intellectual functioning of those referred to the REACH programs during FY16.



In comparison to fiscal year 2015, a slight change in the above distribution is noted. Specifically, fiscal year 2016 saw a decrease in the number of referred individuals with a mild or moderate degree of intellectual impairment and a concordant increase in those functioning within the average or above range (6% in FY15 and 15% in FY16). This change is statistically significant and likely reflects the increasing number of individuals with a primary diagnosis of autism who are seeking services through the REACH programs.

- <u>Psychiatric Diagnosis:</u> REACH is designed to serve individuals who are challenged with both a developmental disability and a psychiatric/behavioral disorder. To be consistent with previous annual reports, information related to diagnostic categories will be provided in this document. However, it should be underscored that this information is reported to give the reader a general impression of the clinical

population being served. It is useful in ensuring that training needs of the REACH programs are appropriate to the population served and to track gross trends. Because there are so many factors that influence the diagnostic information that "follows" an individual into REACH services, the reader is cautioned that the information should not be used to inform decisions related to regional needs or the future direction of the REACH programs. Additionally, some diagnostic information was not consistent with DSM-V nomenclature and was difficult to interpret or appeared to be duplicative of other diagnoses linked to a particular person. In these cases, the data was omitted. Please note that Region II reported only a listing of the diagnoses recorded at the time of referral and they included no frequency data within the diagnostic categories, so Region II has been excluded from the below tables. For all other regions, frequencies listed below may reflect multiple co-morbid conditions. Therefore, there is no concordance between the number of referrals received and the reported frequency of a psychiatric condition. The first table offers diagnostic frequency data. The second table offers a slightly different view of this data, providing a rank ordering of the diagnostic groupings by frequency for each region. Of note is that externalizing disorders are the most common, with only Region I ranking these as second. Also of note is the uniformly low ranking of personality disorder diagnoses, which may not reflect the true rate of prevalence. Individuals with personality disorders are a subset that REACH has identified as challenging the system. In a collection of one time data, over 65 individuals were known to REACH across the state with Personality Disorders. Overall, the rankings are fairly consistent. When they do deviate, it is typically by only one position within the rank.

Diagnostic Category	Region I	Region III	Region IV	Region V
Externalizing Disorders (i.e. impulse control disorder; ADHD; bipolar disorder; intermittent explosive disorder, oppositional defiant disorder)	37	108	97	58
Depression	19	63	20	9
Psychotic Disorders	30	58	44	26
Anxiety Disorders	39	60	22	17
Personality Disorders	4	19	6	10
Unspecified Mood Disorders	9	20	12	8
Substance Use Disorders	4	6	2	3
Other*	15	7	11	6

*Other includes very low rate disorders within the sample, such as pica, dementia, Tourette's Syndrome, TBI, adjustment disorders, eating disorders and conversion disorders.

Region	Externalizing Disorders	Depression	Psychotic Disorders	Anxiety Disorders	Personality Disorders	Mood Disorders (unspecified)	Substance Use Disorders	Other
I	2	4	3	1	7	6	7	5
III	1	2	4	3	6	5	8	7
IV	1	4	2	3	7	5	8	6

V	1	5	2	3	4	6	8	8

Data regarding those diagnostic categories being referred to REACH suggest that a wide breadth of psychiatric disorders is being treated in the population served by REACH. Because one of the primary functions of the REACH programs is to ameliorate the impact of mental illness on the lives of persons with developmental disabilities, it is positive that a full complement of conditions is being treated. Consistent with last year, it appears that personality disorders are being under diagnosed in this population since individuals with intellectual disabilities are more likely than the general population to have a personality disorder*. Therefore, diagnosis of a personality disorder should be both possible and credible in this sample. Additionally, as was noted in last year's annual report, anecdotal evidence suggests that personality disorders are not uncommon among REACH participants. They present a substantial challenge to the existing system and utilize a disproportionate amount of clinical resources. The Commonwealth is currently working on coordinating training in Dialectical Behavior Therapy as applied to those within the DD community. The goal of this training is to build local expertise in managing this challenging clinical population.

- Presenting Problems: Given that externalizing disorders are the most frequently seen psychiatric conditions for adults receiving REACH services, it is not surprising that aggression continues to be the most commonly reported presenting problem. Increased mental health symptoms continue to hold second place in this ranking. Different from last year, however, is the difference between these two data points. In fiscal year 2015, aggression counted for 194 presenting problems versus 190 for increased mental health symptoms. This year that difference is much larger, with 380 service requests made secondary to aggression versus 211 for psychiatric symptoms. This continues to support the conclusion that REACH is addressing the primary challenges that the Commonwealth intended: psychiatric symptomology, the majority of which can be categorized as externalizing disorders, and behavioral challenges, which most often include aggression in some form. It is less clear why the split between aggression and mental health symptoms has become so large. It likely reflects differences in data collection practices, with some regions identifying multiple primary presenting problems while others provide only one. With continued improvements to the data dictionary and increased reliance on the use of the Data Store, it is anticipated that this discrepancy will dissolve.

  The table below provides a summary of reported data on presenting problems. The reader is reminded that there is no concordance between total number of presenting

*Powers, M. (2005). Clinical Guide to Assessment and Management of Personality Disorders in the Adult Person with Mental Retardation and Developmental Disorders.

problems and the number of individuals served as some individuals present with multiple serious challenges at the time of referral while others have only a single need. Additionally, some regions report only the primary presenting problem, while other regions may include concerns that are more secondary in nature. The Data Store addresses this inconsistency so that, going forward, there can be a more linear relationship between data related to presenting problem and referral totals.

Another significant change in the data for this fiscal year is the sharp increase in individuals being referred for service due to suicidal behavior and ideation. Last year, these referrals made up only 13 of the 428 reported presenting problems. This year, that number had jumped to 92 of 911 reasons for service requests. This is a percentage increase of 7 points. This increase has all been seen in Region III. It could be that a correlation exists between this increase in suicidal thought and behavior and the noted increase in the number of individuals presenting for service who function within the normal range of intelligence. Perhaps those with at least average intellectual functioning would be more able to think about suicide, communicate a plan, and even make gestures consistent with a wish to die. To look at this, the percent of referrals made to the programs for individuals with average (or above) intellectual functioning were compared across regions to determine if Region III was serving a larger proportion of this group. This relationship was not borne out. The number of individuals without an ID diagnosis is spread fairly evenly among the five regions, and Region III actually had a smaller percentage of non-ID individuals referred to their program than three of the other regions. The table below shows the percentage per region of referrals that were for individuals without a diagnosis of an intellectual disability or borderline intellectual functioning. The reason for the increase in suicidal symptom presentation is not known at this time.

Region	Percent
I	20%
II	9%
III	11%
IV	16%
V	14%

Presenting Problems	**Region I**	**Region II**	**Region III**	**Region IV**	**Region V**	**Totals**
Aggression	77	107	65	64	67	380
Increased Mental Health Sx	46	57	53	43	12	211
Family Needs Assistance	14	7	22	33	0	76
Loss of Functioning	0	3	14	10	4	31
Suicidal Behavior/Ideation	16	3	68	0	5	92
Self Injury	3	3	16	9	12	43
Elopement	4	7	0	0	2	13

Transition Assistance/ Step Down	2	2	29	4	2	39
Risk of Placement Loss	0	0	5	3	1	9
Sexualized Behavior	0	2	1	0	1	4
Diagnostic Evaluation/Treatment Planning	0	0	3	0	0	3
Service Linkages	0	0	10	0	0	10

Service Utilization

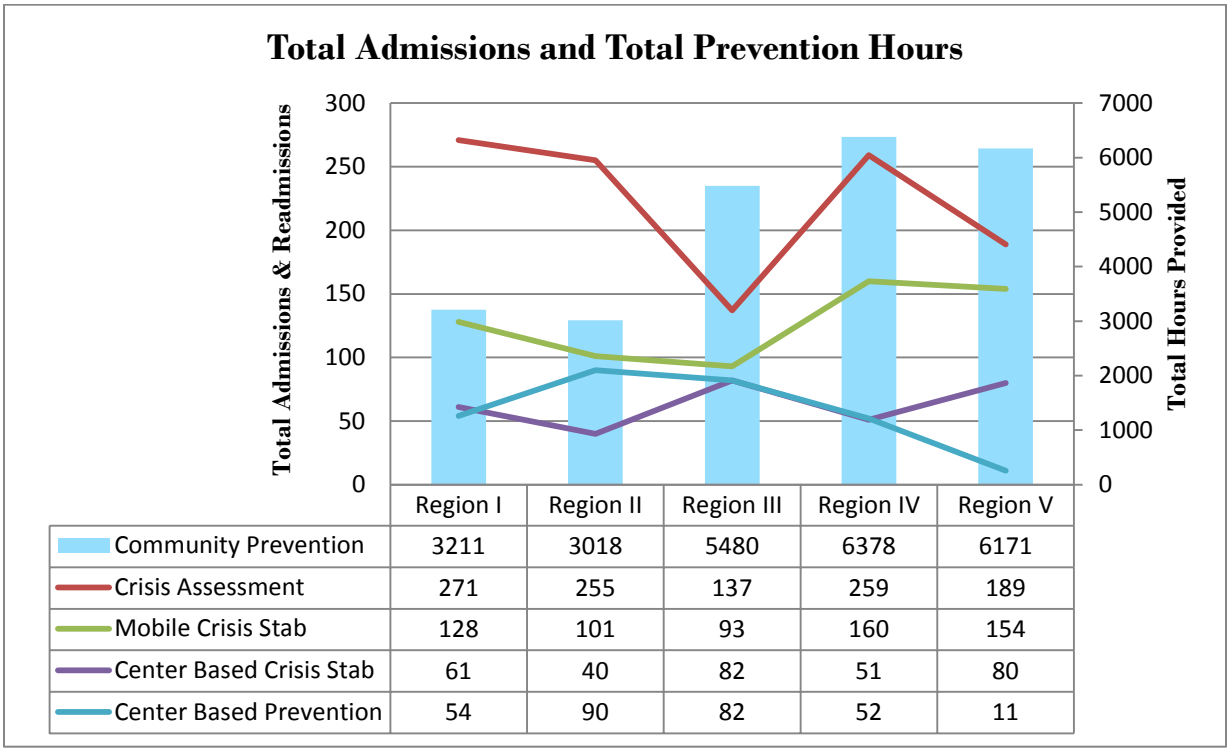
The REACH programs are charged with providing crisis intervention and prevention services to individuals with developmental disabilities and co-occurring mental health and or behavioral needs. In service of this mandate, they provide crisis assessments, home-based crisis intervention and stabilization, center-based crisis intervention and stabilization, preventative stays in the Crisis Therapeutic Homes (CTH), and prevention through training, service planning, active monitoring, and individualized supportive interventions. The chart below summarizes service utilization by type across the five regions. Due to clear regional differences, the data is reported both regionally and in aggregate form, with prevention reported separately for clarity.

As the programs have continued to embed their services into the communities they serve, they are refining the focus of their mission. They are moving toward a more balanced practice model between its crisis intervention and crisis prevention functions. This is in keeping with the philosophy that the most effective crisis intervention is prevention. On the following page, two charts are presented. One provides a comparison of the number of admissions to a service type along with the total number of prevention hours provided. Prevention hours are graphed on the secondary Y axis to avoid dwarfing the other data points.

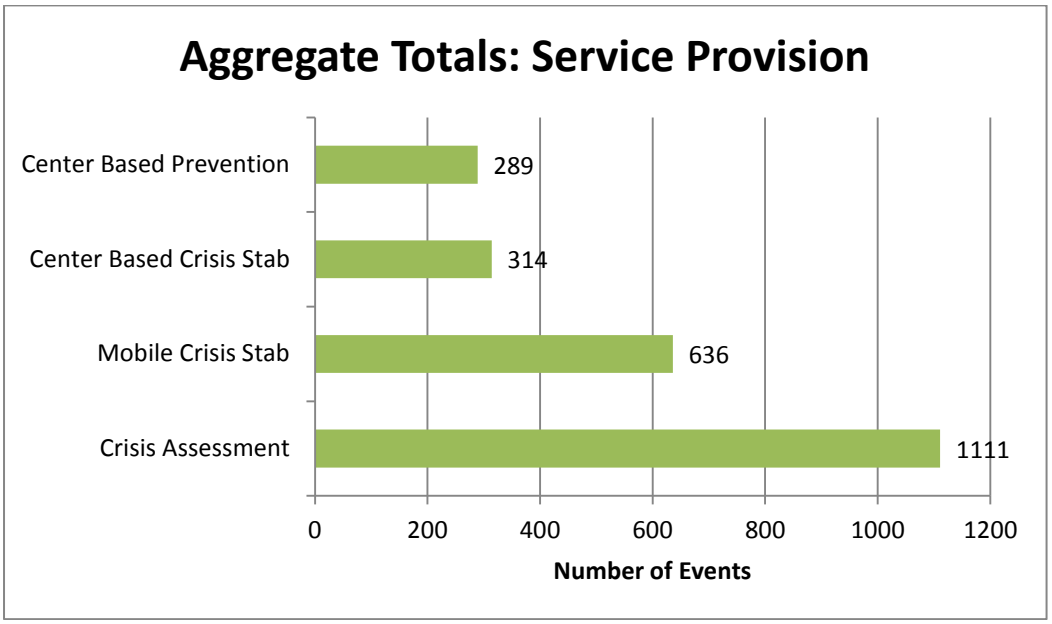
It is the expectation that all individuals opened to REACH will receive prevention services. Therefore, presenting the number of hours provided is a more useful point of comparison than looking at the number of individuals who received prevention work. At the time of last year's annual report, it appeared that an inverse relationship between number of crisis assessments and prevention hours was developing. This relationship is no longer evident as two of three regions with the highest number of crisis assessments also provided the most prevention services. The immediate reasons that this expected relationship has not sustained are not obvious. It could be that Regions IV and V serve a more complex population, that ancillary services are not as well developed in these regions, or that drift exists in the way this variable is being defined and reported. Given that Regions IV and V contain large urban areas within their confines, it seems less likely that service availability would be the most fitting explanation, but more information would be needed to confirm this hypothesis. It is true that all regions are providing much more prevention work than was true for fiscal year

2015. This reflects positive growth for REACH as they now have established the resources and relationships to be more proactive in their communities.

The second chart, titled *Aggregate Totals: Service Provision*, provides statewide totals of services by type. Please note that the graph does not contain totals for prevention services because the unit of measurement is different as noted above. Combining these into a single graph would reduce the visual variability among the data points, obscuring the overall picture.



	Region I	Region II	Region III	Region IV	Region V
Community Prevention	3211	3018	5480	6378	6171
Crisis Assessment	271	255	137	259	189
Mobile Crisis Stab	128	101	93	160	154
Center Based Crisis Stab	61	40	82	51	80
Center Based Prevention	54	90	82	52	11



Type of service rendered is one lens through which service utilization can be explored, and it offers a picture of how clinical service resources are being distributed within the target population. It is also important to consider *where* services are being provided because it offers one avenue for evaluating how embedded the REACH teams are in the communities they serve and how flexible they are in their ability to meet the needs of those they serve. Location of crisis assessments is one proxy for this. The REACH guidelines make clear that crisis responders should, unless specifically contraindicated, report to the scene of the crisis event to complete their assessment. As noted last year in this report, this is important for several reasons. First, an on-site response allows for a therapeutic interaction to be provided by a clinically trained professional, potentially calming the situation *in vivo*. Secondly, the on-site response and initial intervention provides valuable clinical information, resulting in a more accurate assessment of the crisis event. Thirdly, face to face contact provides an opportunity for the individual's support system to receive coaching and modeling on effective intervention strategies at the time they are actually needed. Finally, responding on site creates a buffer between the individual and the emergency room, potentially decreasing the risk of psychiatric hospitalization as an outcome or supporting the individual and the support system through the process when a Temporary Detention Order (TDO) cannot be avoided.

A review of data for FY16 indicates that a majority of assessments took place within the hospital or emergency room setting. This finding is most likely to due to the policy change previously mentioned which took place in January of 2016 that *required* the REACH programs to be contacted whenever an individual with a known *or suspected* diagnosis of DD was to be prescreened. The policy further required that documentation of an exception to this policy be provided to DBHDS each time a REACH program was not contacted. This initiative has greatly increased REACH's involvement in the prescreening process for

individuals being considered for inpatient treatment. It has also been tremendously valuable in reducing the number of individuals who "fall through the cracks".

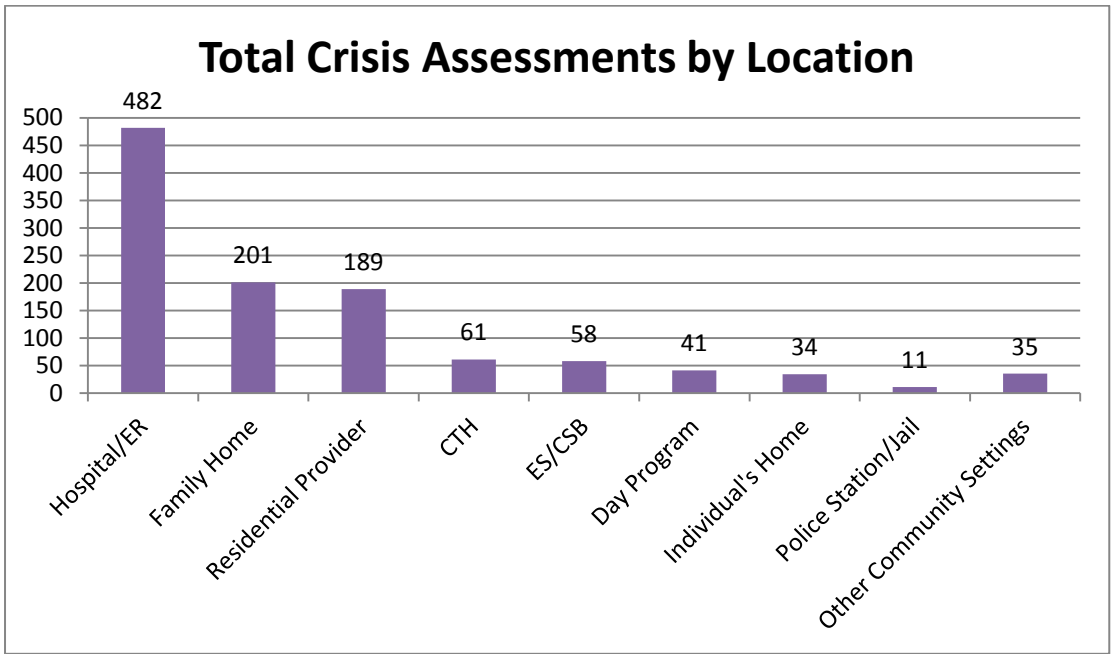
After hospitals and emergency rooms, the second largest number of crisis evaluations occurred within the individual's residential setting, whether a family home, the individual's own home, or within a congregate setting (i.e. group home). This continues to be the more preferred situation as it indicates that assessment and intervention occurred prior to the person becoming an acute danger to themselves or others. Even this rather basic assumption must be viewed with caution, as some regions are successfully diverting the need for on-site crisis assessment through the effective use of telephone coaching and de-escalating. These interventions are captured as an element of call data and are designated as prevention.

This year, a considerable number of crisis assessments took place within the REACH Crisis Therapeutic Homes (CTHs). This number was up sharply from the previous year, rising from 22 to 61. The reasons for this rise are not known at this time, but it is likely that a simple increase in the acuity of the population served does not fully account for this change. Consistent with data from the previous years' annual report, assessments conducted in day programs and miscellaneous community settings occur only occasionally. The category for "Other Community Settings" includes locations such as grocery stores, buses, streets adjacent to the CTH, nursing homes, restaurants, etc.

Regional differences in the data exist, but these differences are very difficult to interpret. For example, Regions I and IV conduct substantially more crisis assessments in hospital or emergency room settings than the other regions do. However, when converted to a percentage of the total assessments for their region, this relationship disappears and Region III assumes that position followed by Region I and IV. Further understanding this number would require knowledge about whether multiple assessments were completed on a single individual over a short or long period of time, if the individual was a new referral to the program or an on-going case, or if any unusually complex clinical circumstances were relevant, among many other considerations.

The number of crisis assessments that take place within the CTHs is another area that differs greatly between the regions. These assessments will occur on occasion as the acuity of a particular individual rises, but it is generally expected that home staff will be able to conduct crisis assessments and resolve the event without having to rely on more highly trained REACH staff. Ideally, formal crisis assessments that occur at the CTH should be unusual. For fiscal year 2016, this number is quite high and well above that reported for fiscal year 2015 (22). It has nearly tripled in fact, totaling 61 assessments. Regions III and IV did not contribute to this number at all. Region I accounted for only nine of these events. Regions II and V were responsible for the majority, with Region II conducting 35 crisis assessments at the CTH and Region V 17. Region II had a needed change in the leadership of their therapeutic home, which appears to have resulted in a significant decline is crisis assessment occurring at the CTH. The high numbers in Regions II and V do suggest that CTH staff in these regions may need additional training in evaluating and addressing crisis situations.

This may be especially true in Region V where these numbers have remained consistent for the three quarters. The individual regions are encouraged to examine their own data to determine what it reveals about their program and how the data can best be used to inform decision making.



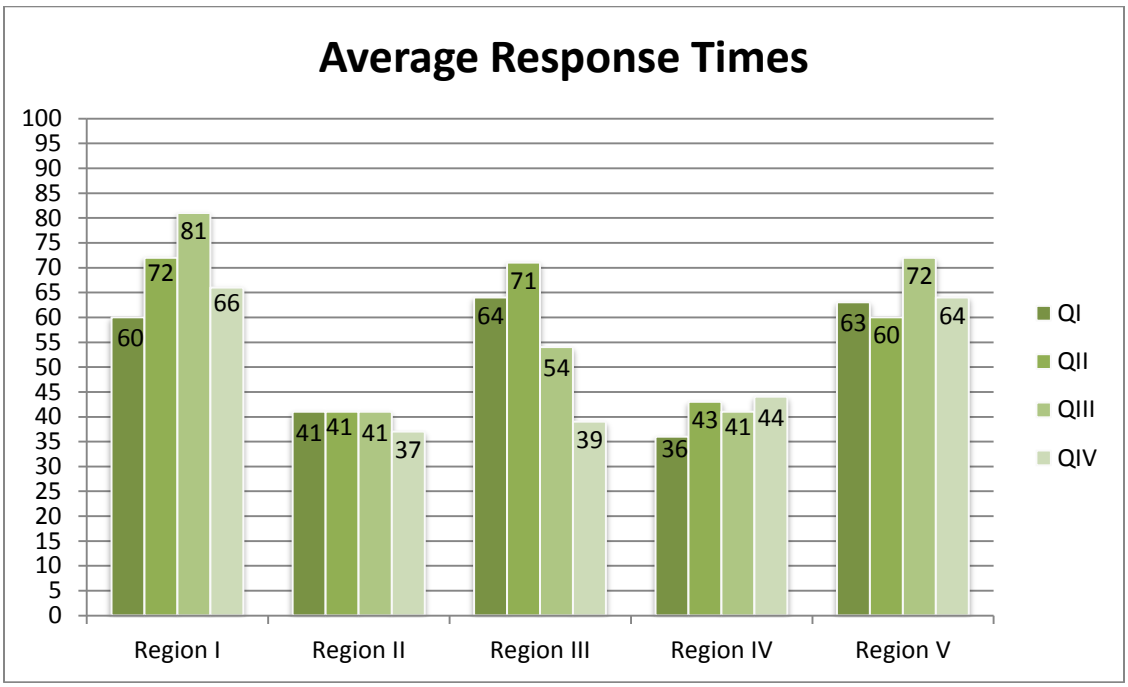
Crisis Response Time

Currently, the REACH programs are well within the bounds of the standards established by DBHDS when response times are averaged within Region. There continues to be a small number of individual events that exceed established expectations. This number has fluctuated over the year, but not substantially. As noted in last year's annual report, the number of overtime responses is now sufficiently small and unsystematic that it can be considered random error. Random error can never be completely controlled or eliminated; thus, reported response times are stable and represent a true measure of time needed to arrive physically to the site of a crisis event.

Consistent with last year's report, average response time data is presented region by region rather than being aggregated across the five programs. This provides for a more accurate review of the data for two reasons. Firstly, the regions have different response time standards, depending upon their status as either rural or urban. Secondly, the physical geography, staffing resources, and organizational structure of the programs differ significantly from area to area. Aggregating the data is only appropriate when the differences between the categories being studied are minimal. This is not the case with the

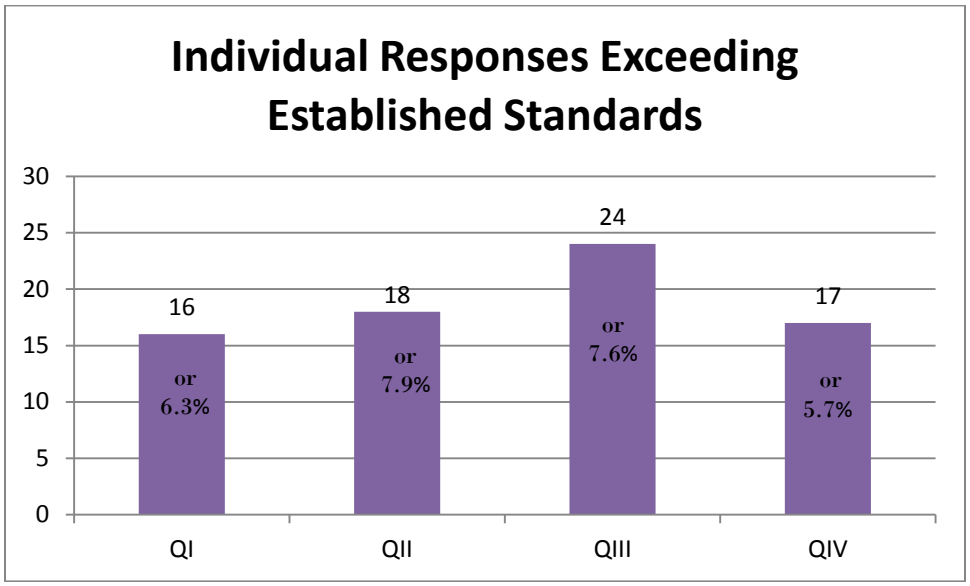
REACH programs. Please note that average response time data was available for all five regions and for all four quarters.

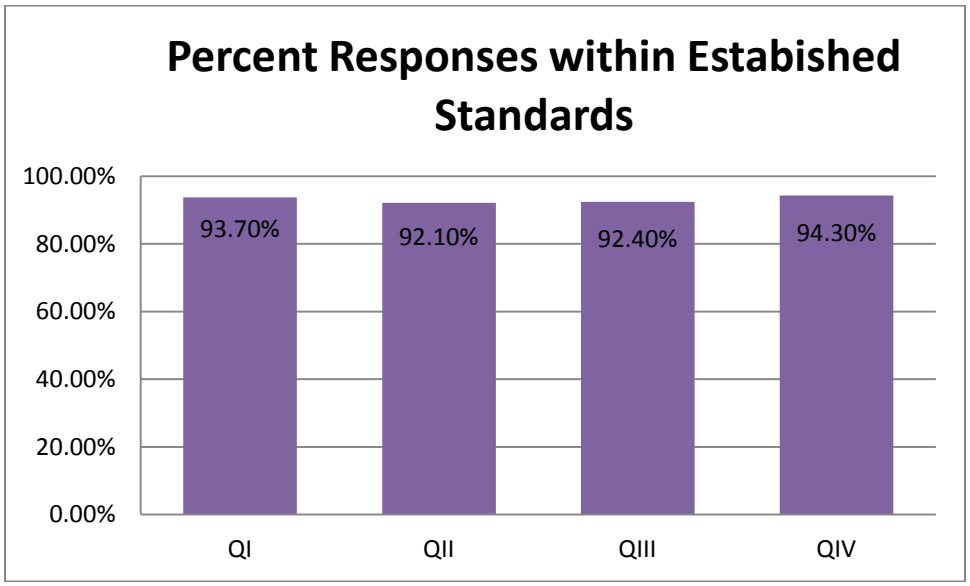
As the chart below depicts, response time patterns differ region by region, although this variability has decreased over the past year. This is likely due to the increased consistency of practices that has developed over this fiscal year as the REACH Standards have been more formally implemented and reinforced. Regions II and IV have very stable average response times, which is somewhat surprising as both are urban regions where traffic flow can be both obstructive and unpredictable. Region II will be adding geographic area to its region in the upcoming fiscal year, which may impact the stability of response times at least temporarily. As the donor to Region II, Region I will be reducing its regional size. Region III's response times appear to be on a declining trend, but they may have little room to further reduce.



Note: Regions I, III, and V are designated rural and have up to 120 minutes to respond, as measured by the average annual response time. Regions II and IV have urban designations, allowing them a 60 minute response time, as measured by the average annual response time.

The charts below summarize data for the number of discrete responses outside of established standards and for the percentage of response that occurred within established standards. Overall, these numbers reflect very positively on the programs efforts to be responsive to the needs of individuals in crisis.

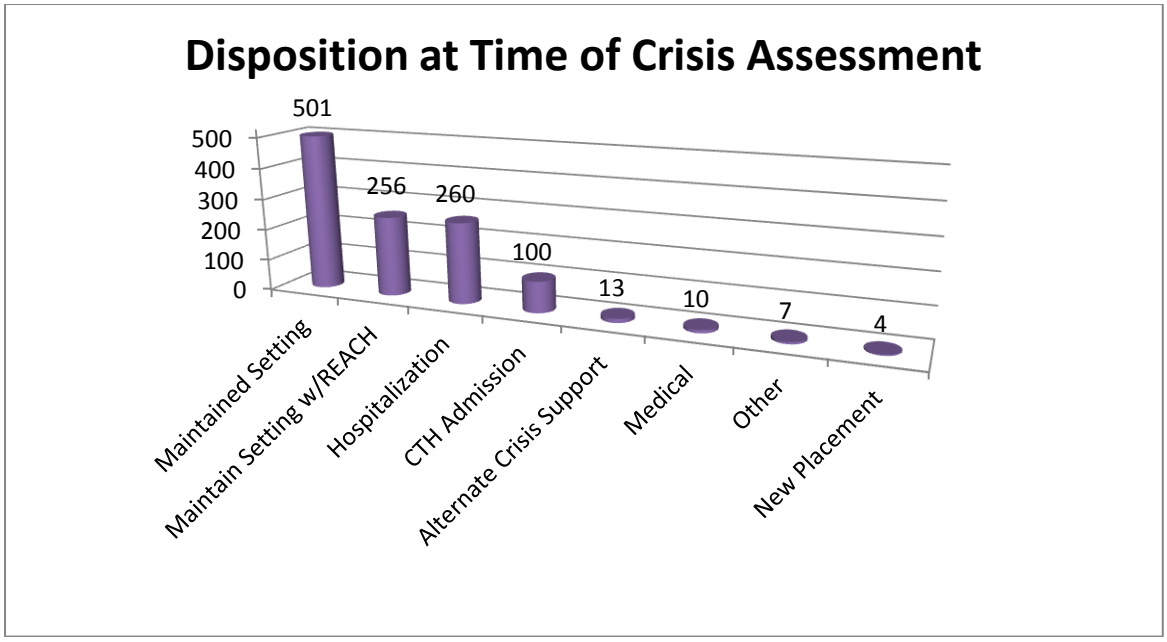


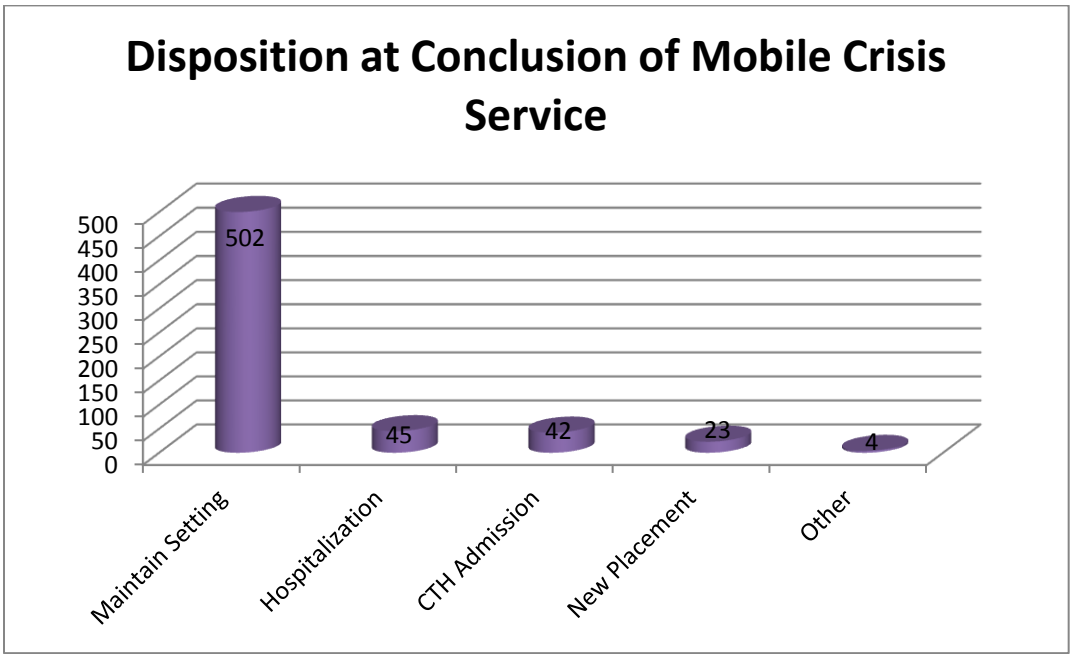


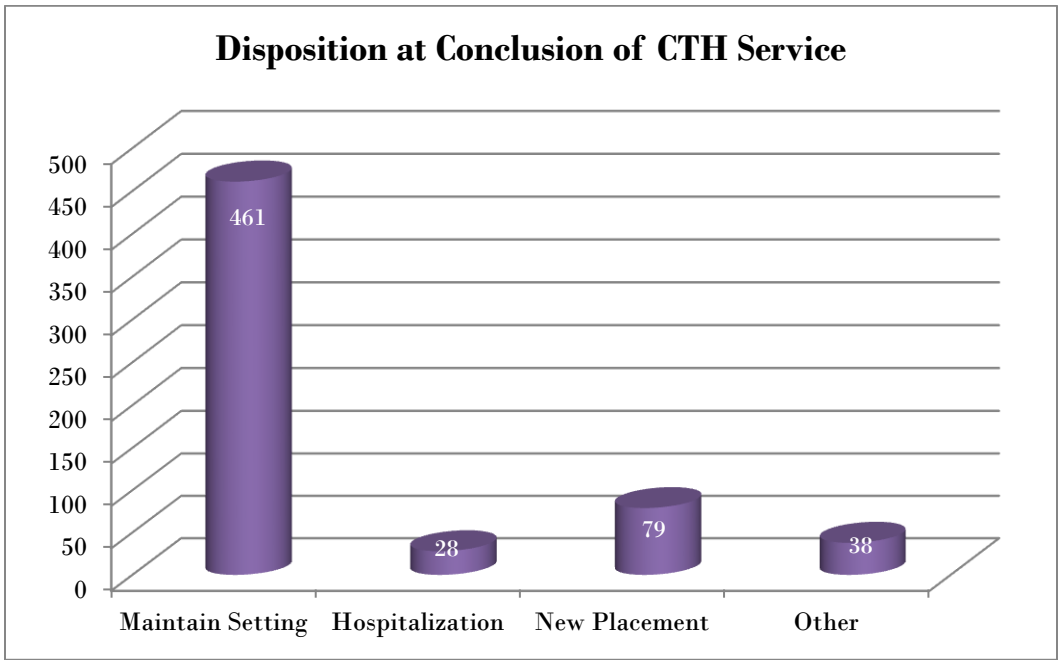
Service Disposition

Service outcomes are one of the measures by which the value of the REACH programs are determined. Residential stability, which foreshadows a good quality of life, is generally the most desirable outcome of REACH intervention. There are times, however, when a poor match exists between the individual and his/her living environment. In these cases, a change of residence may be very healthy, and the REACH programs will facilitate such a change when needed. Nonetheless, in the majority of cases, the person is best served by returning to

or remaining in the home where the crisis initiated, with efforts directed at shoring up the individual's coping skills and the support system's ability to respond in a healthy way. The charts below illustrate the outcomes of the REACH program as defined by placement disposition. Three perspectives are presented: disposition from crisis response, disposition at the close of community based mobile support services, and disposition upon ending a stay at the CTH. The reader will note that retaining residential placement is the primary service outcome across all comparisons. Indeed, it dwarfs the other categories the difference is so great. When disposition at time of crisis assessment is examined, those who ultimately retained their residential situation are broken into two groups: those who remained home without any additional support and those who remained home with the support of REACH community crisis supports. The reader is reminded that, while residential stability is generally considered a positive outcome, medical or psychiatric hospitalization are sometimes the only clinically appropriate disposition to an immediate crisis. The category of "other" includes unusual dispositions, such as moving out of state, jail, etc.







Conclusions & Recommendations

This report has summarized the work of the REACH programs over the past fiscal year. Fiscal year 2016 has seen a number of changes to the programs. The REACH standards have been in place unchanged for 11 months of fiscal year 2016, which has stabilized the service system and allowed for greater cohesion to develop. There has been continued demand for longer stays at the CTHs. In some cases, having individuals for longer stays has had a

neutral effect on the programs, such as offering more community based activities or allowing for a broader range of group activities to avoid overly repetitious treatment experiences. Other adjustments have presented more of a challenge, such as the reduced availability for prevention admissions and the impact on the individual as options and funding are developed to address the need. The Department continues to work collaboratively with case managers to resolve barriers to securing good placements for individuals who have been at the CTH for longer than 30 days and has put systems in place to help assure continued forward movement in locating appropriate placement.

The year has also seen the implementation of the Data Store for more automated data collection and tabulation. The Department has been working closely with the program developers to add additional data elements, align the Data Store more tightly with the operational definitions that the programs use to communicate, and allow each data element to be calculated both regionally and in aggregate. It is anticipated that it will be both possible and practical to use the Data Store in combination with the Department's Data Warehouse to prepare quarterly reports during the upcoming fiscal year.

As the data in this report intimates, Region V has had challenges in meeting the expectations of the Department as it relates to REACH services. Their referrals are low, as are their active cases. They lack a broad referral base, which suggests that their services are not widely sought after in the communities they serve. The high number of crisis assessments being performed at the CTH suggests a lack of stability in that service, although this might also be impacted by the very high number of crisis admissions as opposed to planned, preventative stays. This points to another area of concern, however, and may indicate that the program continues to function from an acute rather than proactive perspective. Reported hours of prevention hours would counteract this interpretation, but, unfortunately, data reporting for the Region has been questionable which has resulted in the region seeking consultation for training, oversight, and monitoring of data collection and entry. The Department is working in concert with the Region to address service provision and data concerns.

This year has also seen an increased focus on service quality, with face to face quarterly reviews of each program providing the structure for these discussions. These reviews focus on both administrative/operational practices as well as clinical cases. They have been helpful in identifying program strengths and unique practices that might benefit the REACH program as a whole and in discussing how shortcomings at the system level impact the work of REACH and could be resolved. Each region has also completed a quality self-assessment and reviewed this with the behavioral psychologist and an outside consultant. This has been a useful tool in guiding a dialogue between the programs and the department that can focus on the issues the program identifies rather than externally imposed requirements or policies. However, it has been determined that this process will need to be revised moving forward as it has some redundancy with the quarterly review process. The Department will be working with its outside consultant to develop an appropriate alternative to this tool to ensure that it remains useful and additive.

The REACH programs are filling a vital role in the continuum of community care for those within the DD community. Once again, referrals have increased this year, the programs have been involved in various community training opportunities, and they have sustained their focus on prevention by providing a substantial number of hours of prevention service. Goals for the coming year are to increase the capacity of CTH bed space to offset the impact of admitting individuals without a residential disposition to the crisis houses, to ensure that the Data Store is fully operational and meeting the data collection needs of the Department, and to improve service quality through additional training of REACH staff (i.e. Positive Behavior Support credential) and of community providers of all types.